WYOMING
Colorectal Cancer Screening Program

Wyoming Colorectal Cancer Screening Program

Helping Wyoming People Detect Cancer Early

March 2009

Provider Manual

Wyoming Colorectal Cancer Screening Program
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Letter from Program Director, Kimberly Rogers

Dear Colleague:

The Wyoming Department of Health Colorectal Cancer Screening Program, in collaboration with the Wyoming Comprehensive Cancer Control Program, and various providers across the state, is implementing a statewide program to provide colorectal screening services to medically underserved Wyomingites, and to increase the awareness and demand for colorectal screening for all Wyoming citizens. The Wyoming Colorectal Cancer Screening Program (WCCSP) is part of a 5-year plan to achieve the Wyoming year 2010 colorectal screening goal in increasing the percentage of Wyoming men and women who have received a sigmoidoscopy or colonoscopy to 60%. This year alone, the WCCSP hopes to screen approximately 700 Wyoming people who are at or below 250% of the federal poverty level. In addition, the program will help those who have no health insurance (or their current insurance does not cover the costs relating to colonoscopy).

You will be a part of the colorectal success by contracting to be a WCCSP provider, and we appreciate your help!

This manual includes a broad overview of the programs components and specific information to help guide operations of the program at the clinic, hospital, and community levels. Use this manual to answer questions about operation of the program and as the standard for care for Wyoming residents screened through the Wyoming Colorectal Cancer Screening Program.

On behalf of all our collaborative partners, welcome to WCCSP. If you have any questions or concerns, please do no hesitate to contact us.

Sincerely,

Kimberly Rogers
Program Director

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Program Description

This document describes the operational components of the Wyoming Colorectal Cancer Screening Program (WCCSP), and defines patient eligibility, approved screening methods, and program logistical and contact information.

Program Purpose

The Wyoming Department of Health, in collaboration with the Wyoming Comprehensive Cancer Control Consortium, and various healthcare providers, laboratories, and facilities across the state, is implementing the WCCSP, a statewide effort to provide colonoscopies to Wyoming residents at or below 250% of the Federal Poverty Level. Provider reimbursement is at the Medicaid-allowable rate. The WCCSP aims to increase the awareness and demand for colorectal screening for all residents of Wyoming.

The WCCSP is funded by general fund monies and was appropriated through the 59th Wyoming State Legislature, Enrolled Act 92, also known as the Wyoming Cancer Control Act.

This program facilitates a plan to achieve the Wyoming Year 2010 colorectal screening goal of increasing the percentage of Wyoming men and women who have had a sigmoidoscopy or colonoscopy to 60%.

The WCCSP is designed to provide colonoscopy screening services to Wyomingites who meet certain criteria, including the following:

- Applicant must have been a resident of the State of Wyoming for at least one (1) year. Applicant must provide proof of residence by presenting a valid Wyoming driver's license, or an identification card issued under Title 31 of the Wyoming Statutes. Applicant shall swear to an oath of residency when completing the application for enrollment.
- Applicant must be age 50 or over, and not eligible for the federal Medicare program.
- Applicant must be at or below 250% of the Federal Poverty Level, as evidenced by most previous year’s Income Tax Statement.
- Applicant must be a patient of a clinic or hospital participating in the WCCSP.
- Upon approval of application for enrollment, Applicant will be eligible for one (1) colonoscopy every ten (10) years, counting any colonoscopy completed before July 1, 2007, or before the applicant became a Wyoming resident.

Wyoming Colorectal Cancer Screening Program
Quality Assurance Team

In order to address program efficacy and quality improvement of an evidence-based screening program, the Wyoming Colorectal Cancer Screening Program (WCCSP) has implemented a Quality Assurance Team to serve in an advisory capacity. The role of this advisory committee encompasses the following areas:

1. Developing and periodically assessing the screening and surveillance guidelines to be used for determination of eligibility for the WCCSP

2. Providing guidance to staff regarding questions about specific patient's eligibility

3. Promoting the program through community level efforts and social marketing campaigns

4. Providing resources to staff regarding medical decisions about treatment of colorectal cancers detected by the WCCSP

The committee will meet in person or via conference call every 4-6 months. The chairperson of the committee will be available to review individual patient questions and will get advice from the other committee members as needed. Individual recommendations will be reviewed at each committee meeting.

Members of the Quality Assurance Team:

James Bush, MD
Chairperson
Staff Physician
Wyoming Department of Health

Brent Sherard, MD, MPH
Director and State Health Officer
Wyoming Department of Health

Joseph Grandpre, PhD, MPH
Deputy State Epidemiologist
Wyoming Department of Health

Alice Preheim
Enrollment Specialist/ WCCSP
Wyoming Department of Health

Linda Chasson, MS
Administrator, Preventive Health & Safety Division
Wyoming Department of Health

Molly M. Bruner, MSN, RNC, Administrator
Community and Rural Health Division
Wyoming Department of Health

Kim Deti
Public Information Officer
Wyoming Department of Health

Kimberly Rogers
Cancer Control Program Manager
Wyoming Department of Health

Ginny Mahoney
Chief of Staff
Wyoming Department of Health

Wanda Webb
Case Manager/Navigator- WCCSP
Wyoming Department of Health

Tracy Murphy, MD
State Epidemiologist
Wyoming Department of Health

Lisa Lucas RN, BSN
State Program Specialist
Wyoming Department of Health

Applicant Eligibility & Enrollment Requirements

The WCCSP will handle all applications to determine eligibility. Eligibility screening will not be the responsibility of the contracting physician. All Wyoming men and women that meet the following criteria are eligible to apply for the program:

1. Applicants age 50 to 64 at average risk for colon cancer
2. Applicants under age 50 at elevated risk for colon cancer due to personal or family history (a physician's recommendation in writing will be required)
3. Applicants who have been a resident of Wyoming for at least one year
4. Applicants must have an income at or below 250% of the Federal Poverty Level (see Table 1)
5. Applicants who are uninsured, or those whose insurance does not adequately cover the cost of a colonoscopy
6. Applicants who are not eligible for the federal Medicare program
7. Applicants will be eligible for one (1) colonoscopy every ten (10) years, including any colonoscopy completed before July 1, 2007, or before the applicant became a Wyoming resident.

Federal Poverty Guidelines 2009

Number of Person in Family Unit	Poverty Line (2007)	250% of Poverty Line (2007)
1	$10,830	$27,075
2	$14,570	$36,425
3	$18,310	$45,775
4	$22,050	$55,125
5	$25,790	$64,475
6	$29,530	$73,825
7	$33,270	$83,175
8	$37,010	$92,525
Each additional person, add	$3,740	$9,350

The Wyoming Colorectal Cancer Screening Program uses poverty guidelines to determine eligibility. The federal government updates poverty guidelines annually. These guidelines are released by mid-February of each year. You may find the current poverty guidelines with calculated percentages at http://www.cms.hhs.gov/MedicaidEligibility/downloads/POV07ALL.pdf.

Approved Screening Methods

Screening Methods Covered

Colonoscopy is the direct examination of the entire colon via colonoscopy. All costs associated with colonoscopy (provider, facility, and pathology) are reimbursed by the program. Colonoscopy is a screening test, but it is often also a diagnostic test and/or a treatment procedure when lesions are identified, biopsied and/or removed. The goal during colonoscopy is that all lesions identified as cancer or polyps (sessile or pedunculated) be excised or, if too large for excision, biopsied, and sent for pathologic examination. An exception is when numerous (over 10-20) small (<5mm) polyps are encountered in the rectum and distal colon; since these are typically hyperplasic polyps, representative biopsies of 5-10 can be obtained. Pathologic evaluation of colonic polyps is critical to determine the individual risk category for colorectal cancer, the first-degree relatives' risk of colorectal cancer, and the proper interval for repeat colorectal cancer testing.

An "adequate" colonoscopy is one that reached the cecum and visualized over 90% of the colonic mucosal surface.

Note: There will be no reimbursement to providers for colonoscopies or related costs performed prior to the WCCSP enrollment start-date. The applicant/patient must have a WCCSP payment voucher to present to the provider prior to the procedure. If applicant/patient does not have proper enrollment approval, the applicant/patient will assume responsibility for any costs relating to procedures performed prior to enrollment approval.

Screening Methods NOT Covered

Procedures not reimbursed by this program include:

- **Flexible Sigmoidoscopy** is the direct visualization of the lower half of the colorectum, often to the point of the splenic flexure, through a flexible sigmoidoscope. This procedure is not reimbursed by the program.
- **Double Contrast Barium Enema (DCBE)** is less sensitive then colonoscopy for colorectal neoplasms. It will therefore be elected as a primary screening method rarely, although it cannot be reimbursed by the program.
- **Virtual Colonoscopy*** (also know as CT colonography).
- **Fecal Occult Blood Testing (FOBT)*** The program will not reimburse for standard or immunochemical FOBT testing.
- **Digital Rectal Exam (DRE)*** should be performed at the time of colonoscopy or sigmoidscopy. This test is NOT reimbursed separately by the program.
- **Post Op Examinations,** office visit following the colonoscopy proceedure.
- **Hemorrhoidectomy,** any hemorrhoid removal
- ***The WCCEDP will not reimburse for no-show appointments by the patient.***

* There is insufficient evidence for the WCCSP to support these screening methods at this time so the program will not cover them.

Note: Medical therapy for Inflammatory Bowel Disease or genetic testing is not reimbursable by the WCCSP.

Wyoming Colorectal Quality Assurance Team
Why Colonoscopy?

The suggested intervention for Wyoming will be the use of the colonoscopy as the main method of screening. This is because colonoscopy has been determined the gold standard for colorectal cancer screening according to many recent studies. By screening via colonoscopy from the beginning, we will be more efficient, accurate, and cost effective.

Fast Facts:

- Complete colonoscopy allows the physician to view the entire colon, identify any suspicious growths, and allows biopsy or removal of a polyp at the very same time it is identified. **(American College of Gastroenterology)**
- An important limitation of sigmoidoscopy is that only the distal colon and rectum are examined; therefore, more proximal lesions may be missed.
- If a method other than colonoscopy is chosen (i.e. flexible sigmoidoscopy, DCBE, etc.), and results on these alternative methods are abnormal, the physician will require a follow-up colonoscopy. **(American College of Gastroenterology)**
- The sensitivity for a single colonoscopy exam is 90% for large polyps and 75% for small polyps. This makes it very likely that any polyps that would become cancer will be found and removed. **Rex DK, Cutler CS, Lemmel GT, Rahmani EY, Clark DW, Helper DJ, et al. Colonoscopic miss rates of adenomas determined by back-to-back colonoscopies. *Gastroenterology* 1997;112:24-8;** and
- It is estimated that 76% to 90% of cancers could be prevented by regular colonoscopic surveillance exams. **The National Polyp Study Workgroup. *N Engl J Med* 1993;329:1977-81**
- In flexible sigmoidoscopy, two types of flexible sigmoidoscopes are currently in use. The 35-cm scope can access only 50%–75% of the sigmoid colon and can be used to detect only 30%–45% of colorectal polyps and cancers. The longer 60-cm scope can be used to examine the entire sigmoid colon in approximately 80% of patients and can, thereby, be used to detect 40%–65% of polyps and cancers. ***Radiology*. 2000;215:327-335**
- The sensitivity of colonoscopy for colorectal cancer (95%) was greater than that for barium enema (82.9%), with an odds ratio of 3.93 for a missed cancer by barium enema compared with colonoscopy. **Rex DK, Rahmani EY, Haseman JH, Lemmel GT, Kaster S, Buckley JS. Relative sensitivity of colonoscopy and barium enema for detection of colorectal cancer in clinical practice.**

Reporting Results

Adequacy of Colonoscopy
Adequate colonoscopy is defined as reaching the cecum and having colonic preparation sufficient to visualize 90% of the colonic mucosa. The colonoscopy procedure report should detail whether the cecum was reached and whether the endoscopist visualized the colonic mucosa adequately.

Findings of Colonoscopy
The colonoscopist's report of optical colonoscopy findings should include polyp(s), mass, lesion/tumor, other lesions, hemorrhoida, diverticular disease, varices, inflammatory bowel disease, ulcerative colitis, and Crohn's disease of the colon. The report should include:

- Number of lesions
- Description (e.g., flat, raised, sessile, pedunculated, bleeding, irregular, etc.), size, and location of each lesion
- Biopsy/management of lesions:
    - biopsy during the colonoscopy with removal of entire lesion(s)
    - biopsy without removal of entire lesion(s)
    - no biopsy during colonoscopy
    - other management of polyp/lesion (tattoo of site, saline prior to biopsy, etc.)
- Recommendations: additional surgery or procedures needed (specify what is needed), or that there is no need for additional surgery or procedures at this time

Colonoscopist's Recommendation
Colonoscopist's recommendation for date of next colonoscopy or other testing is based on the adequacy of the colonoscopy, the optical findings, the results of pathology, and the client's risk category. If the recommendation depends on the results of the histologic evaluation of a polyp then the colonoscopist should provide recommendation contingent on the pathology results (example: if polyp is adenomatous, repeat colonoscopy in 5 years, if hyperplasic repeat in 10 years).

Treatment Recommendation
Based on the findings of the colonoscopy, the usual and customary treatment will be recommended by the medical care provider(s) on a case-by-case basis:

- No further treatment necessary
- Ablation or excision of lesions during colonoscopy
- Surgery

Pathology Reports
A polyp or lesion should be classified by standard pathologic criteria and should include the following:

- Type of polyp or lesion: tubular adenomas; villous adenoma; tubulovillous adenoma; serrated adenoma; hyperplasic polyp; other (mucosal polyp, inflammatory, pseudopolyp, submucosal polyp:lipoma, carcinoid, metastatic tumor, etc.)
- Degree of dysplasia: The diagnosis of any adenoma indicates the presence of dysplasia. Special mention should be made of the presence of high grade dysplasia (including severe dysplasia, carcinoma in situ and intramucosal carcinoma)
- Presence of involvement of stalk/margin: If high grade dysplasia or carcinoma is present, determine whether the stalk or margin of the specimen is free of involvement. *Note: This applies to large polyps removed by snare excision. It is often not possible to evaluate the margins of small polyps removed by biopsy alone.*

An invasive carcinoma on biopsy or polypectomy specimen should be classified as follows:

- **Differentiation**
  Note whether the carcinoma is well, moderately, or poorly differentiated
  If carcinoma is arising in adenomatous polyp:
    - Presence or absence of lymphatous/vascular invasion
    - Margins: Note whether the margin is involved, distance of the carcinoma from the margins/stalk, or distance of the carcinoma from the cauterized margin of the specimen

Follow-up of Colonoscopy/Inadequate Colonoscopy

If a provider determines that a colonoscopy is inadequate, the provider should determine if and when additional procedures are necessary to complete the screening. Follow-up colonoscopy due to an inadequate initial screening colonoscopy **is** reimbursable by the WCCSP.

Provider Reimbursement

The WCCSP provides reimbursement to WCCSP-contracted providers for colonoscopies at the rate paid under the Wyoming Medical Assistance and Services Act (Medicaid). All participating health-care clinics, endoscopy and pathology providers and affiliated facilities may be paid for services provided though the program. The WCCSP must have a full provider system in place in order to begin referring WCCSP enrollees to a provider. This includes contracts with facilities, providers, labs, pathologists, and anesthesiologists/anesthetists (as needed).

I. Payment Policy

A. Allowable Services: The Program will pay for colonoscopies and related diagnostic services. Allowable services include colonoscopy and pathology laboratory fees. **The following services may be reimbursed at Wyoming Medicaid rate for WCCSP-enrolled clients:**

1. Pre-operative consultation fee
2. Colonoscopy: Flexible, proximal to splenic flexure, diagnostic with or without collection or specimens
3. Colonoscopy with single or multiple cold biopsy
4. Colonoscopy with directed submucosal injection(s) of any substance
5. Colonoscopy with control of bleeding
6. Colonoscopy with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery, or snare technique
7. Colonoscopy with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
8. Colonoscopy with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
9. Level IV surgical pathologies, gross and microscopic examination
10. Special stains (list separately in addition to code for primary service); Group I for microorganisms (eg Gridley, acid fast, netheanamine silver)
11. Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains
12. Immunohistochemisty (including tissue immunoperoxidase)
13. Anesthesia fees (including conscious sedation)
14. Facility Fees

Alternative reimbursement codes: The following codes will be reimbursed on a case-by-case basis upon review of the WCCSP billing office:

15. Pathology consultation during surgery
16. First tissue block, with frozen section(s), single specimen
17. Each additional tissue block with frozen section(s)
18. Cytologic examination (eg, touch prep, squash prep), initial site
19. Cytologic examination (eg, touch prep, squash prep), each additional site

B. Non-allowable Services: There are services that are not allowable for reimbursement by the WCCSP. Payment for these services will be the responsibility of the patient and the patient must be notified by their provider of any services that are not covered. **Services NOT covered by the WCCEDP are as follows:**

1. There will be no reimbursement to providers for colonoscopies or related costs performed prior to the WCCSP enrollment start date. The applicant/patient must have a WCCSP payment voucher to present to the provider prior to the procedure. If applicant/patient does not have proper enrollment approval, the applicant/patient will assume responsibility for any costs relating to procedures performed prior to enrollment approval.
2. Other screenings, such as Standard or Immunochemical Fecal Occult Blood Testing (FOBT), flexible sigmoidoscopy, barium enema, stool mutational analysis, CT and MRI colonography (virtual colonoscopy), screening tests requested at intervals sooner than are recommended by program guidelines (unless the Department provides a written waiver to applicant pursuant to a written explanation letter by the attending physician), medical therapy for inflammatory bowel disease, or genetic testing are not reimbursable by the WCCSP.
3. Reimbursement for adverse events is not covered by the WCCSP. The program will only reimburse for procedures identified in the WCCSP approved-CPT coding list.
4. The WCCSP shall not reimburse for follow-up surgery or additional medical care if an actual cancer or other condition requiring additional care is found.
5. Post operative visits.
6. ***The WCCSP will not reimburse for no-show appointments.***

C. Payment Rates: Colonoscopy and associated diagnostic services (as identified in the WCCSP approved CPT Code List) will be paid by the WCCSP at the Wyoming Medicaid allowable rates. For circumstances where multiple biopsy/removal techniques are used during one colonoscopy, the program will pay 100% of the allowable Medicaid reimbursement for the service of the highest cost, then 50% of the allowable Medicaid reimbursement amount for the second service and 25% of the allowable Medicaid reimbursement amount for the third and sequential techniques. If several specimens from a single colonoscopy are reviewed by pathology, the program will pay for every specimen.

II. Procedure to Receive Payment for Screening Services

A. Billing Forms

The WCCSP uses two different billing forms based on provider type:

- Hospitals: Uniform Billing (UB)-92
- All Other Providers: Centers of Medicare and Medicaid Services (CMS)-1500 (previously the HCFA-1500)

For guidance in completing the UB-92 and the CMS-1500, consult the Equality Care General Provider manual by Affiliated Computer Systems (ACS). Claims will be processed by the WCCSP

and then sent to Wyoming State Auditors for payment. Please send claims, with required documentation attached, to the WCCSP at the following address:

Alice Preheim
WY Colorectal Cancer Screening Program
6101 Yellowstone Road, Ste 259A
Cheyenne, WY 82002

For billing claims or questions please contact the WCCSP at 1-866-205-5292.
Note: The WCCSP does not supply UB-92 or HCFA 1500 forms.

B. Required Billing Documentation

A claim will not be paid until the required medical documents are received by the WCCSP. Providers must submit the following documents along with the billing form:

1. Pre-operative consultation bill: Submit the history and physical
2. Colonoscopy bill: Submit the procedure report, which includes:
    - Pre and post procedure diagnoses
    - Description of procedure
    - Findings
    - Recommendations
3. Pathology bill: Submit the pathology report
4. Facility bill: No additional documentation required
5. Anesthesia bill: No additional documentation required

C. Health Insurance Portability Accountability Act (HIPAA) (45 CFR 164.506)

The Wyoming Department of Health WCCSP is a covered entity. A covered entity may, without the individual's authorization, use or disclose protected health information for the purposes of treatment, payment, and health care operations activities. For example:

- A health care provider may disclose protected health information about an individual as part of a claim for payment to a health plan.
- A health care provider may send a copy of an individual's medical record to a specialist who needs the information to treat the individual.
- A covered entity may disclose protected health information for the treatment activities of any health care provider (including providers not covered by the Privacy Rule).
- The WCCSP will have up to 45 days to pay for the eligible services.

D. Reimbursement Policy

Claims are reviewed for missing information and necessary attachments and the patient's payment voucher. Claims are submitted electronically on a daily basis by WCCSP checks are processed in accordance with policies set by the State Auditor's office.

The WCCSP reimbursement amount is considered *payment in full* as noted in the contract between the WCCSP and the provider (see Provider Contract, Section 4, Payment, Part A). An explanation of when a provider may bill a program-enrolled patient is outlined in the Provider Contract (see Section 4, Payment, Part A). The WCCSP also requires timely filing of bills (see Provider Contract, Section 5, Responsibilities of Contractor, Part D).

III. Audits

Personnel from the WCCSP may conduct audits of clinical and financial records to ensure compliance with the WCCSP standards, rules and regulations, and to verify the validity of reported services.

Suggested Audit Process: The audit process will typically consist of the following steps:

1. The WCCSP identifies that an audit will be undertaken and the service provider is contacted to arrange a pre-audit teleconference.
2. A teleconference occurs to discuss the audit process, scope and objectives and information such as medical records that will be required. A date for the site visit will be established.
3. The program's accounting services personal will visit the site and review information pertinent to the audit, develop findings and recommendations. The type and extent of field work will vary according to the scope and objectives of the audit. The site visit may entail examining the medical records to ensure that items for which payment was requested are documented in the medical record.
4. A meeting or teleconference will be held in which the auditors discuss preliminary audit results (compliance and exceptions).
5. A formal report of the audit findings will be forwarded to the clinic, hospital or pathology laboratory. The report will describe those findings that are in compliance, exceptions to expected practice and recommendations for improved management/reporting practice.
6. The service provider will have the opportunity to respond to the auditor's findings and recommendations in writing within 30 days of receipt of audit report.
7. The WCCSP accounting services personnel will follow the progress toward resolution of audit issues and may include recommended corrective actions in future service agreements with clinics, hospital and pathology laboratories. Continued non-compliance with audit recommendations is grounds for termination of the service agreement.

Program Evaluation

The WCCSP will be evaluated to assess program efficacy and assure funding to maintain and expand the program. The WCCSP will define clinical, process, and patient satisfaction outcomes that will measure program reach, efficiency and quality of services provided. Data reports will be shared with the Wyoming State Legislature, stakeholders in Cancer Prevention and Control, healthcare providers and any other interested parties. The following data will be collected and analyzed:

- Clinical and Process-related Outcomes:
  Data will be collected from WCCSP applications and from the medical documents of all patients that are screened through enrolled providers.
- Patient Satisfaction Outcomes:
  A patient satisfaction survey will be mailed to all patients that are screened through the WCCSP. The survey will include questions relating to outreach materials, navigation activities, the screening procedure, and follow-up care.
- Screening Rates:
  In order to measure the impact of the program on state-wide colon cancer screening rates both among the uninsured and the insured population, data from the Behavioral Risk Factor State Survey collected before and after the initiation of the program will be analyzed.

Patient Navigation

The WCCSP provides patient navigation support to educate and guide patients through the colorectal screening and treatment process. The primary purpose of the navigator is to improve health care delivery to populations who have limited or no access to the health care system. The role of a patient navigator was created to eliminate barriers and guide patients through the medical system in a culturally sensitive manner. The WCCSP will partner with other organizations in providing navigation services. Patient navigation services include:

- Assisting patients through the screening process to assure that people prepare adequately for the colonoscopy and show up for their appointment.
- Assisting patients in follow-up of abnormal screening results or colorectal cancer diagnosis.
- Identifying and coordinating resources for the patient who may require physical, emotional, financial, or other support through their cancer journey.

Mass Media and Public Awareness

The WCCSP will carry out marketing and promotional efforts that include general public awareness and education, local patient outreach, and program eligibility information.

Initial marketing outreach includes:

- Coordination of mass mailings to Wyoming residents that may be eligible for screening. These mailings include a letter from the WCCSP and a promotional colorectal screening brochure. Both the letter and brochure can be provided in English and Spanish.
- Posters and other materials for clinic exam and waiting rooms to encourage all patients to discuss colorectal screening with their health care providers.
- Web based information about the WCCSP, targeted at clinics, providers, and patients through the website: http://www.health.wyo.gov/phsd/ccp/index.html

Other types of mass media will be pursued as the program expands. This media will be created for both the general public and specific patient populations, including medically underserved populations. This may include television, radio, newspaper, billboards, buses, and other types of media. The WCCSP will coordination with various partners and stakeholders who are also interested in providing colorectal cancer awareness.

Contact Information

Wyoming Colorectal Cancer Screening Program
6101 Yellowstone Road, Suite 259A
Cheyenne, WY 82002

Toll Free: 866-205-5292
Outside of state: (307)777-2932
Fax: (307)777-2426

Web: http://www.health.wyo.gov/phsd/ccp/index.html

Surveillance Recommendations

The WCCSP, under the recommendation of the Wyoming Colorectal Cancer Program Quality Assurance Team, has suggested various surveillance guidelines to aid in decision-making after polypectomy and cancer resection.

Guidelines

Guidelines for Colonoscopy Surveillance after Polypectomy: A consensus Update by the U.S. Multi-Society Task Force on Colorectal Cancer and the American Cancer Society

Full Article CA Cancer J Clin 2006;56:143-159

A. Surveillance Recommendations

1. **Patients with small rectal hyperplastic polyps** should be considered to have normal colonoscopies, and therefore the interval before subsequent colonoscopy should be 10 years. An exception is patients with a hyperplastic polyposis syndrome. They are at increased risk for adenomas and colorectal cancer and need to be identified for more intensive follow up.

2. **Patients with only one or two small (< 1 cm) tubular adenomas with only low-grade dysplasia** should have their next follow-up colonoscopy in 5 to 10 years. The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician).

3. **Patients with 3 to 10 adenomas, or any adenoma $\geq$ 1 cm, or any adenoma with villous features, or high-grade dysplasia** should have their next follow-up colonoscopy in 3 years providing that piecemeal removal has not been done and the adenoma(s) are completely removed. If the follow-up colonoscopy is normal or shows only one or two small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years.

4. **Patients who have more than 10 adenomas at one examination** should be examined at a shorter (< 3 years) interval established by clinical judgment, and the clinician should consider the possibility of an underlying familial syndrome.

5. **Patients with sessile adenomas that are removed piecemeal** should be considered for follow up at short intervals (2 to 6 months) to verify complete removal. Once complete removal has been established, subsequent surveillance needs to be individualized based on the endoscopist's judgment. Completeness of removal should be based on both endoscopic and pathologic assessments.

6. **More intensive surveillance is indicated when the family history may indicate hereditary nonpolyposis colorectal cancer.**

B. Additional Surveillance Considerations

1. The present recommendations assume that colonoscopy is complete to the cecum and that bowel preparation is adequate. A repeat examination should be done if the bowel preparation is not adequate before planning a long-term surveillance program.

2. There is clear evidence that the quality of examination is highly variable. A continuous quality improvement process is critical to the effective application of colonoscopy in colorectal cancer prevention.

3. A repeat examination is warranted if there is a concern that the polyp is incompletely removed, particularly if it shows high-grade dysplasia.

4. Endoscopists should make clear recommendations to primary care physicians about when the next colonoscopy is indicated.

5. Given the evolving nature of guidelines, it is important that physicians and patients should remain in contact so that surveillance recommendations reflect changes in guidelines.

6. Pending further investigation, performance of fecal occult blood test is discouraged in patients undergoing colonoscopic surveillance.

7. Discontinuation of surveillance colonoscopy should be considered in persons with serious comorbidities with less than 10 years of life expectancy, according to the clinician's judgment.

8. The application of evolving technologies such as chromoendoscopy, magnification endoscopy, narrow-band imaging, and computed tomography colonography are not established for postpolypectomy surveillance at this time.

Guidelines for Colonoscopy Surveillance after Cancer Resection: A consensus Updated by the American Cancer Society and the U.S. Multi-Society Task Force on Colorectal Cancer

Full Article CA Cancer J Clin 2006:56-160-167

A. Post-cancer Resection Surveillance Colonoscopy Recommendations

1. **Patients with colon and rectal cancer should undergo high quality perioperative clearing.** In the case of nonobstructing tumors, this can be done by preoperative colonoscopy. In the case of obstructing colon cancers, computed tomography colonography with intravenous contract or double contrast barium enema can be used to detect neoplasms in the proximal colon. In these cases, a colonoscopy to clear the colon of synchronous disease should be considered 3 to 6 months after the resection if no unresectable metastases are found during surgery. Alternatively, colonoscopy can be performed intraoperatively.

2. **Patients undergoing curative resection for colon or rectal cancer should undergo a colonoscopy 1 year after the resection (or 1 year following the performance of the colonoscopy that was performed to clear the colon of synchronous disease).** This colonoscopy at 1 year is in addition to the perioperative colonoscopy for synchronous tumors.

3. **If the examination performed at 1 year is normal, then the interval before the next subsequent examination should be 3 years.** If that colonoscopy is normal, then the interval before the next subsequent examination should be 5 years.

4. **Following the examination at 1 year, the intervals before subsequent examinations may be shortened if there is evidence of hereditary nonpolyposis colorectal cancer or if adenoma findings warrant earlier colonoscopy.**

5. **Periodic examination of the rectum for the purpose of identifying local recurrence, usually performed at 3 to 6 month intervals for the first 2 or 3 years, may be considered after low anterior resection of rectal cancer.** The techniques utilized are typically rigid proctoscopy, flexible proctoscopy, or rectal ultrasound. These examinations are independent of the colonoscopic examinations described above for detection of metachronous disease.

B. Additional Recommendations Regarding Post-cancer Resection Surveillance Colonoscopy

1. These recommendations assume that colonoscopy is complete to the cecum and that bowel preparation is adequate.
2. There is clear evidence that the quality of examinations is highly variable. A continuous quality improvement process is critical to the effective application of colonoscopy in colorectal cancer prevention.
3. Endoscopists should make clear recommendations to primary care physicians about when the next colonoscopy is indicated.

4. Performance of fecal occult blood test is discouraged in patients undergoing colonoscopic surveillance.

5. Discontinuation of surveillance colonoscopy should be considered in persons with advanced age or comorbidities (with less than 10 years of life expectancy), according to the clinician's judgment.

6. Chromoendoscopy (dye-spraying) and magnification endoscopy are not established as essential to screening or surveillance.

7. Computed tomography colonography (virtual colonoscopy) is not established as a surveillance modality.

Note: The WCCEDP does not provide funding for the treatment of colorectal cancers detected by the Program at this time. If no other payment sources are available to the client for treatment of colorectal cancer (i.e. private insurance), it is suggested that they contact the WCCEDP case manager for patient navigation services to discuss alternative options.